Commonwealth of Virginia

Flexible Reimbursement Accounts Program

Administrative Handbook

COMMONWEALTH OF VIRGINIA

FLEXIBLE REIMBURSEMENT ACCOUNTS PROGRAM

ADMINISTRATIVE HANDBOOK FOR BENEFITS ADMINISTRATORS

Updated 1/1/03

TABLE OF CONTENTS

Introduction

The Commonwealth of Virginia Flexible Benefits Program is sponsored by the Department of Human Resources Management (DHRM) as a vehicle to provide additional benefits to eligible employees of the Commonwealth on a pre-tax basis, resulting in tax savings to the participating employees and the Commonwealth. The Plan qualifies as a Cafeteria Plan authorized by Section 125 of the Internal Revenue Code. Fringe Benefits Management Company (FBMC) is the third party administrator of the Flexible Reimbursement Accounts (FRA).

This manual is written by FBMC, in cooperation with DHRM staff, for Benefits Administrators and other Commonwealth staff who have responsibilities associated with the Flexible Benefits Program. Its purpose is to communicate general information and procedures essential for implementation and ongoing administration of the Program. It is important that staff at the Commonwealth and their counterparts at FBMC have a clear understanding of the interface necessary to administer the Program and the role each plays to assure its accuracy and success.

This manual is designed for use by the agency Benefits Administrators and Payroll Offices in conjunction with the Flexible Benefits Sourcebook.

Should you need to reach us, here are some quick reference numbers:

Account Manager
Fringe Benefits Management Company

3101 Sessions Road	or	P. O. Box 1878
Tallahassee, FL 32303		Tallahassee, FL 32302-1878

Client Services	(800) 872-0345	(850) 425-6220 (Fax)
Quarterly Review	http://www.fbmc-benefits.com	

Refer *customers* to our service lines as follows:

Customer Service Line	(800) 342-8017
IVR Information Line	(800) 865-3262
Reimbursement Request FAX Line	(850) 425-4608
FBMC Website	http://www.fbmc-benefits.com

The Annual Election Period

Enrolling Through EmployeeDirect

During the Fall Annual Enrollment period (November 1-30), employees can enroll in a Flexible Reimbursement Account (FRA) by using EmployeeDirect, the Commonwealth's health benefits enrollment and information system, on the Web or by submitting a Flexible Reimbursement Account (FRA) Election Form. Employees can set up a FRA for the first time, if the eligibility requirements have been met, or enroll in a Medical or Dependent Care FRA for the new plan year*:*

Employees can

1. *Use EmployeeDirect on the Web in one of two ways. Either go:*
   - *Directly to* **http://edirect.state.va.us**, *or to*
   - *The DHRM Web page at* **www.dhrm.state.va.us** *click on Health Benefits and then the EmployeeDirect tab.*
2. *Complete a FRA Election Form*

Enrollment Materials

Each Benefits Administrator has been provided a PowerPoint presentation that explains concepts associated with premium conversion and IRS Reimbursement Accounts. This PowerPoint presentation is available on the DHRM web site for use by the Benefits Administrators and employees. The PowerPoint presentation can be found at DHRM web site: http://dhrm.state.va.us/hbenefit.htm

Please encourage employees with questions about the Reimbursement Accounts to contact FBMC's Customer Service line at (800) 342-8017. FBMC Customer Service representatives will explain the benefits of the accounts and help employees to determine when the Reimbursement Accounts are more beneficial than the IRS approved tax credits. In addition, (with answers to a few simple questions), the Customer Service representative can prepare a tax-savings analysis to help the employee determine the cost and tax savings of the benefits being considered for selection.

Enrollment Interface

Shortly after the open enrollment ends, FBMC receives enrollment data from the Commonwealth that contains an election record for every employee who enrolled in one or both Reimbursement Accounts.

This information is then used by FBMC to create a master file record for every participant.

FBMC receives the enrollment data that includes all reimbursement accounts elections that have been **confirmed** through EmployeeDirect or entered manually into the Benefit Eligibility System (BES). The data contains each participant's name, social security number, and the annual election amount of each reimbursement account.

DHRM distributes to all agencies a listing showing all enrollees for the Annual Election period. **It is the responsibility of each agency to promptly notify FBMC of any enrollee having less than 24 payroll cycles.**

The data is consolidated to create an employee profile or master file record for Consolidated Billing staff to use in the processing of payrolls, and for Customer Service staff to view in assisting participants with various account inquiries

Benefits Notification

After enrollment information has been posted to FBMC's system, the benefit notification process begins. The process confirms, between FBMC and the participating employees, the Flexible Benefits Reimbursement Accounts elections that will become effective with the new plan year.

Every employee, who enrolls during open enrollment and elects a Reimbursement Account, receives a Confirmation Notice from FBMC. The Confirmation Notice is in addition to the confirmation notice received if the employee enrolls through EmployeeDirect. The FBMC notices are mailed to each employee's home address.

The Confirmation Notice lists the benefit(s) selected and the per pay amount to be deducted from the employee's paycheck. The text of the Confirmation Notice instructs employees to carefully review the notice, compare the information with their EmployeeDirect confirmation letters, if applicable or their copy of the election form and report discrepancies to the Agency Benefits Administrator's attention immediately.

The Benefit Administrator should make contact with the Employee Services team at the Office of Health Benefits at DHRM to provide a written explanation of the discrepancy and the corrective action requested. DHRM will review the request and make the necessary correction if possible.

Note: *Direct Deposit forms and instructions are also included with each Confirmation Notice.*

Plan Maintenance

Payroll Interface

FBMC is responsible for managing the payroll deductions associated with the Reimbursement Accounts. This includes: the proper posting of all payroll deductions within three (3) business days of receipt of processable payroll information, the creation and maintenance of a dual-entry accounting system to track employee records, and to consolidate premium records. FBMC receives payroll deduction information for each plan participant, compares the data to the *master file* records, creates discrepancy reports, records payroll deduction entries to all reconciled participant reimbursement accounts, and makes payment to participants based on fund availability, account status and IRS rules and regulations. FBMC also maintains a *suspense* account to post unreconciled payroll entries that are awaiting resolution by the Benefits Administrators and/or Payroll Officers.

The payroll interface between FBMC, the Central Payroll System, and the nine individual decentralized Payroll Centers is the critical component in plan management.

Payroll Deduction Data

Payroll deduction information is provided to FBMC from the payroll centers. Since payroll deduction information is provided on a per-payroll basis and the enrollment information is provided as an annual total, the amounts may not agree. Should some rounding errors result, FBMC will round down to the closest integer.

Agency Codes:

Department of Accounts - FBMC assigned agency code C
College of William and Mary & Virginia Marine Institute - FBMC assigned agency code D
Virginia Polytechnic Institute & State University - FBMC assigned agency code E
Virginia Military Institute - FBMC assigned agency code M
James Madison University - FBMC assigned agency code G
Virginia Commonwealth University - FBMC assigned agency code H

George Mason University - FBMC assigned agency code I
Virginia Economic Development Partnership - FBMC assigned agency code J
Old Dominion University – FBMC assigned agency code O
Virginia Tourism Authority – FBMC assigned agency code T

Payroll deduction data is mailed to FBMC's Consolidated Billing processing staff. For quick reference, the address is as follows:

ATTN: FBMC Consolidated Billing
Fringe Benefits Management Company
P. O. Box 1878
Tallahassee, FL 32302-1878

A hard copy of the payroll deduction data should be forwarded to DHRM - Attn: Flexible Benefits Program Manager.

FBMC never actually *receives* the dollars that represent reimbursement account annual elections; however, FBMC has *access* to the dollars to pay reimbursement account claims requests. Very simply, the Commonwealth of Virginia's Department of Treasury maintains a deposit account for the reimbursement account deductions; FBMC maintains a controlled disbursement, zero balance account that is tied to the deposit account for daily funding purposes.

Reconciliation Process

When payroll deduction data is received it is used to create temporary files that are then compared to the master files. A *discrepancy report* is generated that lists records that do not match the master files. This report is called the Payroll Reduction List.

The **Forms** section of this handbook contains a sample of the Payroll Reduction Listing report. This report includes the employee's name and type of account, and compares the expected payroll deduction amount to the actual amount received. This report is a summary of problems encountered that we are unable to resolve when processing the payroll.

The Account Specialist reviews the report, makes any *known* adjustments, and notes on the report what is needed to resolve the discrepancy. The employee can also be crossed off if nothing additional is needed. The report is then forwarded to the payroll contact for final resolution.

A brief explanation of each discrepancy is needed. To make it easy, the explanation can be hand written and returned to FBMC right on the report itself. Please include what action is being taken, if an adjustment is needed and state if a form will be forwarded to FBMC.

The resolved discrepancies must be returned to FBMC on or before the date of the following payroll to assure that the same discrepancy does not appear again. Our preferred method of receiving the resolved discrepancies is by FAX. For quick reference the FAX number and address is as follows:

ATTN: FBMC Consolidated Billing
FAX # 1-850-514-5803
Fringe Benefits Management Company
P. O. Box 1878
Tallahassee, FL 32302-1878

The Payroll Reduction List for the payroll is forwarded to the payroll contact with a detailed instruction sheet that describes the report and how discrepancies are to be resolved.

The Account Specialist will include his/her name and phone number on the instruction sheet and is the primary contact for answering questions regarding the report.

Special note: *Please remember this is an IRS approved Section* 125 *plan and benefits are offered on a pre-tax basis. If a refund is due to a participant, it must be handled through payroll to assure the appropriate taxes are applied.*

Suspense Process

Suspense occurs when a participant's payroll deduction is different from the amount expected; i.e. more money received than expected, less money received than expected, or received money and no money was expected. The expected amount represents the amount that should be received based on enrollment information.

When the payroll deduction is more than the expected amount, the amount expected is paid to the account and the remainder is posted to suspense. When the payroll deduction is less than the expected amount, all money is posted to suspense.

Account Specialist Procedures:
It is the Account Specialist's responsibility to work with the client to resolve all deduction discrepancies in a timely manner. Our goal is to only have items in suspense as a result of processing the most recent payroll.

New Hire Enrollment

Throughout the plan year, elections are handled by EmployeeDirect or by paper enrollment. A camera-ready election form is included in the Forms section of this manual for duplication or can be downloaded from the DHRM web site at http://www.dhrm.state.va.us/hbenefit.htm

When the employee completes the form, it is returned to the Benefits Administrator. A Benefit Eligibility System (BES) record is created according to standard agency procedure.

Eligibility for Participation

To participate in a Flexible Reimbursement Account, an employee must first meet the eligibility requirements of the State Health Benefits Program. In addition, each component of the Flexible Reimbursement Account has its own eligibility requirements.

Employees can enroll, during an Election Period, if they meet the following eligibility requirements.

(1) Medical Reimbursement Accounts

Employees who have maintained eligibility to participate in the State Health Benefits Program for six continuous months are eligible to enroll in the Medical Reimbursement Accounts. It is not necessary that the employee, or his/her dependents, actually be participating in the State Health Benefits Program in order to participate in the flexible reimbursement accounts. The initial election period will be the 31-day period preceding the completion of six (6) months of eligibility for the Health Benefits Program.

(2) Dependent Care Reimbursement Accounts

Each employee who is eligible to participate in the State Health Benefits Program is also eligible to enroll in the Dependent Care Reimbursement Accounts Plan. Eligibility begins on the first day of eligible full-time employment as determined by

the State Health Benefits Program. The employee must enroll into the account within 31 days of the date of hire.

All accounts will be effective the first of the month following receipt of the completed election form or enrollment action through EmployeeDirect.

If two (eligible) state employees are married, they may each elect to participate in the Flexible Reimbursement Account(s). The employees must be made aware of the Plan Limits on the election amounts. While each employee can enroll in the Medical Reimbursement Account for the maximum annual amount of $5000.00, the Dependent Care Reimbursement Account has limits of $5000.00 total for married, filing jointly. (Refer to page 17 of this handbook). The limits are listed on the enrollment form and included in the Flexible Benefits Sourcebook for the employee's reference.

The Benefits Administrator forwards a copy of the BES screen and the completed election form (if available) to FBMC. For quick reference, the address is as follows:

ATTN: FBMC Enrollment Processing
Fringe Benefits Management Company
P.O. Box 1878
Tallahassee, FL 32302-1878

Mid-Year Payroll Deduction Changes

Implementing Payroll Deduction Changes

We begin this section with a caution: ***changes to payroll deduction amounts are not discretionary.*** Plan deductions as indicated on pre-tax enrollment forms must be taken unless some other deductions take priority (for example: retirement, health benefits, garnishment, legal judgment) or there are not sufficient funds from which to take a deduction.

The reason for the caution is that the Flexible Reimbursement Accounts program qualifies as an IRS Section 125 Cafeteria Plan. As such, the program must follow all rules and regulations associated with Section 125, as well as any additional requirements written in the Plan Documents. According to the IRS Code, once an employee makes an enrollment election and directs a specific payroll contribution to be allocated to specific benefits on a pre-tax basis, the amount or the benefits cannot be altered during the course of the plan year unless a *qualifying event,* as defined by the IRS, has occurred.

Changes in Status

According to the IRS regulations governing Section 125 Cafeteria Plans, when an employee experiences a change to his/her family situation or status, a change can be made to the employee's pre-tax salary reduction election.

However, the proposed change must be ***consistent with*** the type of change experienced. That is, contributions and benefit changes must be a necessary or appropriate result of the Changes in Status. The change must be made within a reasonable and specified timeframe. With the Commonwealth of Virginia, the timeframe for notification is within thirty-one (31) days of the qualifying event.

Under the Internal Revenue Code, qualifying events, which allow a Change in Status, include:

- marriage or divorce
- spouse or dependent's death
- dependent's birth or adoption
- spouse begins or ends employment
- spouse or employee change from full-time to part-time employment or vice versa; spouse or employee take an unpaid leave of absence
- either spouse or employee have a significant change in health coverage resulting from spouse's employment

Please refer to the DHRM web site at http://www.dhrm.state.va.us/hbenefit.htm for information on "Enrolling and Making Changes" under the Health Benefits and Flexible Benefits Programs.

Once the election change has been processed through BES, the Benefits Administrator forwards a copy of the BES screen and the new election form (if applicable) to FBMC's Change in Status Specialist. For quick reference; the FAX number is 1-850-425- 6220.

A new confirmation notice is generated and mailed to the employee's home address as soon as FBMC is notified and processes the change.

Leave of Absence

Leave of Absence with full or partial pay:

As long as an employee is still receiving pay, flexible benefits elections will be maintained through the end of the plan year.

Leave without Pay (LWOP), including FMLA:

An employee who goes on leave without pay during a plan year may continue his/her Reimbursement Account(s) by paying the premiums on an after-tax basis through the end of the plan year or the leave without pay, whichever comes first. An employee on leave without pay may not enroll for the next plan year during annual enrollment. However, returning from leave without pay is a qualifying mid-year event that allows the start of an account in the new plan year. Benefits Administrators are responsible for counseling the employee on the options available when going on leave without pay. The employee can elect:

1. Pre-pay option, where the employee is given the opportunity to prepay the deductions on a pre-tax basis, prior to the leave.
2. Pay-as-you-go option, whereby the employee is given the opportunity to pay with post-tax and/or pre-tax monies (to the extent the employee receives compensation).
3. Reduce or terminate participation in the reimbursement accounts(s) at the end of the month he/she goes on leave. The full month's contribution is required to keep the account active for the month.

It is important to note that if an employee elects **not** to continue his/her Medical Reimbursement Account while on leave, reentry into that account for the remainder of that plan year is forbidden. The exception to this rule relates to any benefits that must be reinstated following a return from family medical leave.

Arrangements must be made with the agency payroll office for the employee to pay his/her deductions on an after-tax basis and for those monies to be deposited into the Commonwealth's Flexible Concentration Account. If the employee is on unpaid leave, and the employee elects the pay as you go option, the agency must collect the FRA deduction(s) from the employee and deposit the money into the Flexible Concentration Account following the process outlined in the Department of Accounts (DOA) Commonwealth Accounting Policy and Procedures (CAPPS) Manual. The agencies must also send a copy of the payroll information to DHRM, Att: Flexible Benefits Program Manager for documentation. DHRM will notify FBMC.

Dependent Care Flexible Reimbursement Account (DCFRA) Note:

If an employee has a DCFRA, the FMLA provides an exception to the Change in Status rules that permit the employee to decrease the DCFRA election when going on **paid** leave. Although salary reductions continue while an employee is on paid leave, the employee is not actively at work, an IRS requirement for an expense to be eligible for reimbursement under the DCFRA.

If the employee goes on unpaid leave and the salary reductions cease, the employee cannot continue to contribute to the DCFRA. However, the employee can request reimbursement for eligible expenses until they have exhausted their account balance or the end of the plan year.

Virginia Sickness and Disability Program (VSDP)

Short Term Disability (STD)

As long as an employee is still receiving pay under Short-term Disability (STD), flexible benefits elections will be maintained through the end of the plan year. (Note: See the DCFRA Note listed above). If an agency is unable to take the flexible reimbursement deduction while an employee is on STD due to reduced pay and/or the hierarchy of required deductions such as legal judgements, garnishments etc., the employee will be required to pay the missed deduction on an after-tax basis to maintain the account for the remainder of the plan year or until he/she returns from STD, whichever comes first.

Long Term Disability (LTD)

Employees on long-term disability (LTD) have the option of continuing their medical reimbursement account through the end of the plan year. The employee may need to be offered Extended Participation of the Medical Reimbursement account. Refer to the Extended Participation section of this manual. (Note: Dependent Care will terminate at the end of the month LTD begins).

Returning to Work from LTD

If the employee has been on LTD and returns to work during the same plan year, they may resume the pre-tax payment into the medical reimbursement account provided they maintain the account during their absence. The employee can make a new prospective election to the dependent care reimbursement account.

Transferring between State Agencies

Employees who transfer between state agencies have not incurred a change in status as provided for under the provisions of the Flexible Benefits Plan Document. Therefore, changes to a participant's election, including an election to either begin or terminate participation, are prohibited when an employee transfers between agencies.

It is the "terminating" agency's responsibility to notify the "employing" agency as to which benefit(s) the employee is enrolled. In addition, the terminating agency is responsible for the collection of **all** Flexible Reimbursement Account election amounts due to the plan through the end of the month in which the employee transferred employment.

However, so as not to disadvantage employees whose wages are an insufficient amount for taking the full month's pre-tax contributions, (such as an employee who transfers early in the month), the terminating agency should request that the employing agency collect any election amount(s) due for the month.

Regardless of the reason, if the terminating agency fails to collect the employee's election amount(s) prior to the employee's transfer, any outstanding election amounts are to be collected. Upon receiving notification, the employing agency must collect the outstanding election amount(s) as soon as reasonably possible, within two pay cycles and within the Plan Year for which they are due.

A copy of the Benefits Eligibility System (BES) screen and CIPPS year-to-date account information should be provided to the payroll office of the employing agency.

Reimbursement Account Processing

FBMC takes a very conservative approach to the reimbursement request adjudication process. Processors are trained extensively on IRS rules and regulations as well as specific client plan documents. Any questionable areas are referred to our Compliance and Consulting Team and to the IRS as needed. At all times our guiding principle is to keep our plans in compliance.
An employee can FAX their reimbursement request to FBMC. (For quick reference the fax number is (850) 425-4608), or mail to:

Fringe Benefits Management Company
Att: Flexible Spending Accounts
P.O. Box 1878
Tallahassee, FL 32302-1878

All requests received are date stamped and immediately entered into our processing system. This permits FBMC's Customer Service representative, IVR Information Line and web site to immediately confirm to a participant who may inquire that their requests were received.

A reimbursement processing specialist reviews the data for accuracy, completeness, and validity of payment based on the rules and guidelines. The results of the review are entered into FBMC's processing system and reimbursement payment is issued as appropriate. The entire process from mail receipt to processing to disbursement takes up to five business days.

FBMC has two mechanisms to disburse employee reimbursement payments. A reimbursement *check* by mail is the most common mechanism to disburse authorized reimbursement requests. However, it is not the quickest way. Participants can complete the direct deposit authorization form that permits FBMC to reimburse their requests by direct deposit.

Reimbursement Request Forms

FBMC includes a reimbursement request form in the employee's confirmation notice – this gets the employee started. With each reimbursement request payment or notice of deposit the employee will receive another form.

A small supply of forms is provided by FBMC to each Benefits Administrator. However, should the Benefits Administrator supply of forms be exhausted or if it is inconvenient for the employee to receive a form from a Benefits Administrator, the employee can be directed to contact FBMC's Customer Service, the IVR Information Line or Web site to request additional forms.

Ineligible Expenses

A request may not be eligible for payment for several reasons. For example:

- Documentation of the service is incomplete
- The request form is incomplete or unsigned
- Service is outside the period of coverage
- Service does not meet IRS guidelines and is ineligible for payment
- The account balance is zero

Regardless of the reason, FBMC notifies the employee by letter that the request cannot be paid and why. Specific instructions are provided for the employee to resubmit the request as applicable.

Lost/Misplaced Reimbursement Checks

If an employee loses or destroys an FRA reimbursement check or if the employee never receives an issued check, he/she should contact the FBMC Customer Service line to report the loss and request a replacement. A Customer Service representative will explain the 10-day waiting period imposed before *stop pay* procedures are initiated with the bank.

When confirmation of the stop payment has been received and it is confirmed that the check has not cleared the bank, FBMC's Client Accounting staff will mail a replacement check to the participant via First Class Mail.

If it is determined that a misplaced or undelivered check has cleared the bank, a copy of the check and endorsement will be sent to the employee for verification of signature. If the signature appears to be a forgery, an affidavit is sent to the employee for signature and FBMC coordinates with the bank to initiate forgery procedures based on standard banking rules and guidelines.

Account Information

FBMC's 12-hour Customer Service line or 24-hour IVR Information Line or the Web site at http://www.fbmc-benefits.com is available for participant inquiries. The inquiry screens used by our Customer Service Representatives and the IVR system are tied to FBMC's *master files* and contain the most up to date information regarding participant accounts.

Participants who actively use their accounts - meaning they are submitting reimbursement requests on a regular basis - receive constant information about their accounts via their checkstub or notice of deposit.

FBMC distributes a quarterly statement of account deposit activity.

All participants receive a statement of account deposit and disbursement activity in October with a reminder of the IRS *use it or lose it* provision associated with Reimbursement Accounts.

Appeals Process

The appeals process is a mechanism to allow an employee to request that an action or a decision be reconsidered based on further research and discussion due to extenuating circumstances. An appeals process is not required by IRS Code or by any other rules or regulations related to flex benefits plans; however, the Commonwealth of Virginia's Flexible Benefits Program does provide for an appeals process.

Fringe Benefits Management Company (FBMC) handles all appeal requests related to Reimbursement Account processing, (for example, appeals related to the manner in which a request was authorized or payment denied). All other appeals should be directed to the Department of Human Resources Management (DHRM).

FBMC employs an Appeals Specialist who handles all paperwork and who convenes and leads an Appeals Panel to review all requests. The panel consists of three to five FBMC managers, and a representative from FBMC's Compliance or Legal Department. Panel members are selected based on their expertise in benefit management as well as their knowledge of IRS rules and regulations.

Many appeals requests will be unique and will be handled on a case-by-case basis; however, each decision reached will begin to set precedent for similar future requests. For this reason, we require written rather than verbal requests; we document in writing all decisions to grant or deny appeals requests; and we maintain a filing system by employee name, cross-referenced by the type or category of request.

Decisions are reached objectively and are influenced only by IRS requirements and similar past requests.

Decisions are reached in which any reasonable person with knowledge of the rules and regulations governing the plan would agree.

Decisions in direct violation of IRS guidelines, or the plan documents are avoided unless it can be documented that the circumstances were not the fault of the employee, (for example, confirmed misinformation provided during enrollment).

Finally, we will not put the entire plan in jeopardy. When in doubt, we contact the IRS for guidance.

When an employee wishes to appeal the handling of a reimbursement request or the determination of medical necessity, he/she should be instructed to contact FBMC's Customer Service line to discuss the request.

The Appeals Specialist will instruct the employee to submit the request in writing, including the action the employee is grieving, and why the employee feels it is incorrect, the specific relief the employee seeks, and any documentation that would support the employee's view of the situation.

The Appeals Specialist processes the paperwork and convenes the Appeals Panel. A decision is reached to approve or deny the request and the employee is notified in writing.

The entire process takes approximately thirty (30) days from receipt of the written request.

Compliance and Consulting Services

Quarterly Review

FBMC's General Counsel publishes the "Quarterly Review". The Quarterly Review contains articles and information concerning all aspects of Section 125 Cafeteria Plan management. The publication is published on a quarterly basis, and can be downloaded from FBMC's Web site, www.fbmc-benefits.com/quarterlyreview.

Extended Participation

Extended Participation is a term that DHRM uses to describe coverage required of government employers under the provisions of the Public Health Service Act. These are the same provisions, which apply to private employers under the Consolidated Omnibus Budget Reconciliation Act of 1986. Under certain circumstances, a participant who would ordinarily lose coverage because of Qualifying Events is a Qualified Beneficiary who may elect to continue health coverage under the State Health Benefits Program (Extended Coverage) at his or her own expense. As with Extended Coverage for health benefits, employees who are enrolled in a Medical Reimbursement Account may choose Extended Participation in the Flexible Benefits Program through the end of the current plan year.

Employees who are enrolled in a Medical Reimbursement Account may also choose to extend their current participation in that program if, on the event date, the benefit available for the remainder of the plan year is greater than the amount of Extended Participation premiums (employee's contribution) due for the remainder of the plan year. Contributions may be made on an after-tax basis in the form of a check payable to Fringe Benefits Management Company (FBMC).

For a full discussion of qualifying events and eligibility that allow for Extended Participation, please refer to your Health Insurance Manual (HIM); Section 2 (Extended Coverage).

FBMC handles *Extended Participation* of benefit coverage for Medical Reimbursement Account participants and dependents that wish to continue this benefit.

Note: When a Plan participant terminates his or her employment, all pre-tax benefits will cease on the last day of the month in which the employee is terminated. The Plan prohibits participants from making subsequent payments to the Plan unless they exercise their rights under Extended Participation.

The **employee or qualifying beneficiary** must notify the Benefits Administrator of the qualifying event and his/her desire to extend participation in the Medical Reimbursement Account. The Benefits Administrator then notifies FBMC. For quick reference the address is as follows:

A TTN: Benefits Continuation
Fringe Benefits Management Company
P. O. Box 1878
Tallahassee, FL 32302-1878

When the Benefits Administrator notifies FBMC of the qualifying event, FBMC forwards by regular mail an *Extended Participation Notification of Rights* letter and an application form to the employee or beneficiary. The employee/beneficiary has sixty days to complete and return the application form to FBMC.

Upon receipt of the application, FBMC will send an initial bill to the employee/beneficiary that will be effective from the date coverage is lost. Premiums from the interim period are included on the bill and must be paid to keep the coverage in force under Extended Participation. The employee/beneficiary is given the option to make payments monthly, quarterly, semi-annually, or annually. Contributions **may not** be made on a pre-tax basis in a lump sum paid out of the final paycheck.

Benefits will remain in effect throughout the coverage period as long as premiums are paid. As a courtesy, FBMC notifies each participant thirty days prior to the time that benefits are discontinued.

The initial application is the only opportunity that the employee/beneficiary will have to select benefits for continuation under Extended Participation. However, once selected, the employee/beneficiary can discontinue at any time during the *coverage period.*

A participant would want to continue the account under Extended Participation so not to forfeit unused account dollars. To clarify further, the period of coverage for a Medical Reimbursement Account ceases the end of the month in which a qualifying event occurs. An employee can continue to submit requests for reimbursement for services incurred up to the date the period of coverage ends. However, if an employee has not incurred services equal to the balance existing in the account, he/she will forfeit the dollar balance. An option is to continue the account through Extended Participation, thereby extending the period of coverage to allow additional expenses to be incurred within the continued coverage period.

A Closer Look

Reimbursement Accounts

An overview

A Flexible Reimbursement Account (FRA), also known as a Flexible Spending Account (FSA), is an account established with tax-free employee contributions, for reimbursement of employee out-of-pocket health care or dependent care expenses. These accounts are governed by IRS guidelines for Section 125, and 213, 105 and 129 Code. IRS Publications 502 and 503 can also be used to provide some basic guidelines for eligibility of expenses; however, it is important to note that these publications were produced primarily for the use of individual tax return submission and cannot be used independently to determine expense eligibility for Section 125 FSA plans. Because of this, claims must be substantiated with detailed documentation of the services.

The plan allows employees to direct a portion of their salary through payroll reduction to an FRA. Taxes are then calculated only on the salary remaining after the allocations to the FRA are taken out, creating a lower tax liability.

Contribution Maximum and Minimum

The IRS provides specific contribution limits and allows each plan to provide additional limits as deemed appropriate. For this plan the set minimum and maximums are:

FRA Account	Minimum Amount	Maximum Amount
Medical Expense FRA	$480.00 Annually (Note: $20.00 per pay if enrolling after January 1 plan year start date)	$5,000 Annually
Dependent Care FRA	$480.00 Annually (Note: $20.00 per pay if enrolling after January 1 plan year start date)	Annual amount = varies depending on the employee's federal tax filing status. ** See below.

** Generally, you can deposit up to $5000 into a Dependent Day Care FRA. However, if any of the following apply, the full amount may not be deposited:

a) If married but filing separate federal tax return, maximum contribution is $2,500.
b) If either employee or spouse earns less than $5,000 a year, the maximum contribution is equal to the lower of the two incomes.
c) If the spouse of the employee is a full-time student or incapable of self-care, the maximum contribution is $2,400 a year for one dependent and $4,800 a year for two or more dependents.

Effective 1/1/03, the maximum contribution will be $3,000 a year for one dependent and $5,000 a year for two or more dependents.

Dependent Care Reimbursement Account

The services must be incurred prior to reimbursement. This means that if the employee pays at the first of the month for an entire month of services, the reimbursement cannot be made until

the end of the month. However, the employee may request reimbursement for a portion of the expense as the service period passes by separating the dates of service into weeks and prorating the expense for each week on the reimbursement request form. The original receipt should be attached to the request (the employee should keep a photocopy of the original receipt). The request can be submitted weekly or bi-weekly as the service date ends. For example, if an employee pays $300.00 per month for childcare, the employee can complete a reimbursement request more frequently, if desired, (weekly, biweekly or monthly), as long as the requests are made after the date of service.

The IRS requires that claims be substantiated by an independent third party; thus all requests for reimbursement must be accompanied by documentation of the expense. A dependent care receipt must include the following information:

- Date(s) the service was incurred (beginning and ending dates)
- Service provider's name
- Service provider's address
- The amount of the expense . . .
- Federal Tax Identification Number or Social Security number of the service provider. If the provider is tax exempt, this should be noted on the reimbursement request. If the individual service provider does not have a Social Security number, a Green Card number will suffice.
- If the service provider is an individual, his/her signature is required on each receipt.
- A signature is not required for a printed receipt from a Day Care provider.
- It is important to remember that the **ending date of** service **must** have passed to be eligible for reimbursement.

Who is a qualified dependent?

The employee' s dependent under the age of 13 is a *qualified* dependent; however, the employee must claim the dependency exemption when filing his/her tax return.

Any other dependent, regardless of age, who is physically and/or mentally incapable of self-care and resides with the employee at least eight hours a day, is a *qualified* dependent, even if the employee is not able to claim the dependency exemption because that person has income equal to, or exceeding, the exemption amount. According to IRS guidelines, physical or mental incapacity is not being able to dress, clean or feed oneself. In addition, any individual who requires constant supervision to prevent self- inflicted injury or injury to others, is considered to be "incapable of self-care".

Medical Reimbursement Account

To be eligible for reimbursement from a Medical Reimbursement Account, the amounts spent for services must be for medical care. The determination as to what constitutes medical care depends on the nature of the services rendered, not upon the experience, qualifications, or title of the person rendering the service. ***The services must be for the diagnosis, cure, treatment or prevention of disease or for the purpose of affecting the structure or function of the body***. Those expenses, which may be for the purpose of improving one's appearance or merely for the individual's general health, will require a written, signed statement from the attending

physician as to the purpose of the treatment. Orthodontia is a primary example of such an expense and does require submission of a "Proof of Medical Necessity" letter.

IRS Publication 502 can provide some general guideline as to the types of expenses, which are reimbursable. The maximum annual amount will be available throughout the employee's period of coverage (reduced for prior reimbursements made during the same period of coverage). The employee does not have to wait for the cash to accumulate in the account before he/she can use it to pay for their uninsured, eligible medical expenses.

General Reimbursement Account Rules and Guidelines

- Funds deposited in a Dependent Care Reimbursement Account cannot be used to reimburse medical expenses and vice versa.

- Expenses reimbursed from a Reimbursement Account cannot also be claimed on the employee's tax return.

- Expenses paid in advance cannot be submitted for reimbursement until after the services have been rendered.

- Dependent Care reimbursements will be paid to the limit of the amount in the employee's account when the reimbursement check is written. Any balance will be paid as money is credited to the account.

- Medical reimbursements will be paid to the limit of the employee's annual election amount, less any prior reimbursements made during that plan year.

- There is a 90-day *grace period* after the plan year ends during which the employee may continue to submit claims for expenses, which were incurred during the employee's period of coverage. After the grace period, funds remaining in the accounts will revert to the Commonwealth of Virginia.

- FRA requests must be postmarked by March 31 of the following year to be eligible for reimbursement. This corresponds to the plan's grace period.

- Each FRA plan participant will receive a quarterly statement of account activity in April, July, October and January.

- If an employee loses or destroys a FRA reimbursement check he/she should contact the FBMC Customer Service line and request that a stop payment be issued for the check. FBMC will not place a stop payment on a FRA check until ten (10) business days after the check was issued. The complete process takes approximately two weeks before a replacement check is issued.

- Customers will receive a Reimbursement Request Form with their Confirmation Notice after Open Enrollment and with each reimbursement check.

- For more specific information about the Flexible Reimbursement Accounts, please refer to the Flexible Benefits Sourcebook or visit the DHRM website at http://www.dhrm.state.va.us/hbenefit.htm.

Forms, Forms, Forms

This section contains copies of forms that are used for the enrollment and administration of the Reimbursement Accounts.

Benefits Administrators can duplicate any form as necessary.

Additional forms can be obtained by contacting FBMC.

FBMC

Fringe Benefits Management Company

COMMONWEALTH OF VIRGINIA
January 1 - December 31, 2003

FLEXIBLE REIMBURSEMENT ACCOUNT ELECTION FORM

To enroll in or make changes to your Flexible Reimbursement Accounts (FRAs), you may contact your agency's Benefits Administrator, visit the DHRM web site at www.dhrm.state.va.us/hbenefit.htm, or complete this paper election form.

To start, continue or change your account, place the election amount for the plan year in Box 1. Enter the number of paychecks and revised deduction per paycheck for the remainder of the plan year in Boxes 2 and 3 of the appropriate account.

To discontinue participation, place a zero in Box 3 of the applicable account.

Press hard with ballpoint pen.

Social Security #	Agency Number

Name (Please Print) Last	First	MI	E-mail Address

Home Address	City	State	Zip

Daytime Phone	Home Phone	Date of Hire	Date of Birth	No. Pay Periods Per Year	Annual Salary
( )	( )				

ENROLLMENT STATUS ☐ MID-YEAR ELECTION CHANGE* ☐ NEW HIRE ☐ ANNUAL ELECTION PERIOD — Event Date

*Indicate the qualifying mid-year event you have experienced by checking the appropriate box on the back of this form.

Indicate the amount you wish to pay through tax-free salary deduction by completing the sections below.
Complete the worksheets provided in your Flexible Benefits Sourcebook before deciding on the amount.
If you have questions, consult your Flexible Benefits Sourcebook, Benefits Administrator or call FBMC Customer Service at 1-800-342-8017.

In Box #1 indicate the dollar amount you elect to contribute for the plan year.

In Box #2 indicate the number of regular payroll checks you expect to receive during the plan year. (If you are a new employee enrolling after the plan year begins, divide by the number of pay periods remaining in the plan year, based on your effective date.)

In Box #3 indicate the deduction amount per paycheck. (Note: if Box #2 times Box #3 does not equal box #1 exactly, the amount in Box #3 may be changed slightly by FBMC due to rounding). For changes during the plan year, this amount will indicate the revised deduction.

MEDICAL EXPENSE FLEXIBLE REIMBURSEMENT ACCOUNT

For eligible medical expenses incurred by you, your spouse and eligible dependents.
[Minimum is $480 per year; Maximum allowable contribution is $5,000)

Box #1
Total plan year dollar amount from your worksheet _____

Box #2
Number of regular paychecks expected ÷ _____

Box #3
Deduction per regular paycheck = _____

DEPENDENT CARE FLEXIBLE REIMBURSEMENT ACCOUNT

TAX FILING STATUS [PLEASE CHECK ONE]: Minimum is $480 per year

☐ Married, filing separately [maximum - $2,500]
☐ Married, filing jointly [maximum - $5,000]
☐ Single, head of household [maximum - $5,000]

Box #1
Total plan year dollar amount from your worksheet _____

Box #2
Number of regular paychecks expected ÷ _____

Box #3
Deduction per regular paycheck = _____

IMPORTANT. I UNDERSTAND THAT:

- I hereby authorize my employer to reduce my gross salary before taxes are calculated by the total amount of annual salary reduction indicated above.
- Any amount remaining in any FRA not used during this plan year will be forfeited since it cannot be carried forward to the next plan year.
- The funds in one FRA cannot be used to reimburse expenses covered by another FRA.
- Expenses for which I am reimbursed cannot be deducted on my income tax return.
- The funds in any FRA can only be paid out to reimburse payment of eligible expenses actually incurred during my period of coverage.
- The amount of salary deduction will include the items specified above and will continue in effect unless I terminate employment or file an approved change in status with the Benefits Administrator within 31 days of the event.
- I agree that my employer and Fringe Benefits Management Company, the contract administrator, will not incur any liability resulting from either my participation in any FRA or my failure to sign or accurately complete this election form.

Employee Signature	Date Signed

Benefits Administrator Signature	Date Signed

DO NOT WRITE BELOW THIS LINE — FBMC USE ONLY

DATA ENTRY	VERIFICATION	SCANNED	INDEXED	SPECIAL NOTES

SUBMIT YOUR COMPLETED FORM TO YOUR BENEFITS ADMINISTRATOR IMMEDIATELY.

Qualifying Mid-Year Events

You may change a benefit election upon the occurrence of a valid change in status event but only if your change is made on account of, and corresponds with, a change in status that affects your own, your spouse's or your dependent's coverage eligibility. Assuming that these general consistency requirements are satisfied, if the change in status event affects eligibility for a particular coverage, a corresponding change can be made to the same type of coverage.

You must complete and submit this form within 31 days of the event. The Benefits Administrator for your agency will determine if your Change in Status meets IRS regulations. If your change results from a valid Change in Status, your existing benefits will be stopped or modified (as appropriate) at the first of the month following the event (exception: For birth/adoption, Premium Conversion will be effective the first of the month of the birth or adoption).

Please check below which Change in Status event you have experienced below:

- ❑ change in legal marital status, including marriage, death of spouse or divorce
- ❑ change in the coverage/cost of my daycare provider
- ❑ change in the number of dependents, including birth, adoption, placement for adoption or death of a dependent. Existing dependents can also be added whenever a dependent gains eligibility as a result of a valid Change in Status event.
- ❑ change in employment status of employee, your spouse or your dependent, including: termination or commencement of employment; a strike or lockout; commencement or return from an unpaid leave of absence; change in work schedule, including an increase or decrease in the number of hours of employment; a switch between full-time and part-time status, and a change in worksite
- ❑ an event that causes an employee's dependent to satisfy or cease to satisfy the requirements for eligibility coverage due to attainment of age, student status or any similar circumstances as provided under the accident or health plan under which the employee receives coverage, and
- ❑ a change in the place of residence of the employee, spouse or dependent
- ❑ other.

COMMONWEALTH OF VIRGINIA
FLEXIBLE BENEFITS PLAN
2002 CONFIRMATION NOTICES

Participant's Name WL# WORKL SS# 999-99-9999
Participant's Address
City, State Zip

This is to confirm that Fringe Benefits Management Company, the Plan Administrator, has processed your enrollment form. Please check to ensure your first paycheck matches the benefits and amounts listed.

Reimbursement Account	**Per-Pay**	**Annual**
Dependent Care Reimbursement Account	$200.00	$2000.00
Medical Expense Reimbursement Account	$200.00	$2000.00

Please verify the per-pay deduction amount shown here. If the amount is incorrect or if you have any questions, contact your local Benefits Administrator.

If you have any questions regarding your benefit selections, please call:
FRINGE BENEFITS MANAGEMENT COMPANY
8AM - 8PM, MONDAY- FRIDAY
TOLL FREE
1-800-342-8017

PLAN YEAR _____

FLEXIBLE SPENDING ACCOUNT • REIMBURSEMENT REQUEST FORM

PLEASE READ THE INSTRUCTIONS ON THE BACK OF THIS FORM PRIOR TO COMPLETION.
PLEASE STAPLE SUPPORTING DOCUMENTATION TO THE BACK OF THIS FORM

A. NAME _____ HOME PHONE ( ) _____ DAY PHONE ( ) _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

SOCIAL SECURITY NO. _____ EMPLOYER _____

Do you have coverage for medical expenses? Yes ☐ No ☐
Is your medical coverage provided through an HMO plan? Yes ☐ No ☐
Is any portion of the service covered by your medical coverage? Yes ☐ No ☐

Was the amount applied to your deductible: Yes ☐ No ☐
Was the amount you paid a co-payment? Yes ☐ No ☐

SUMMARY OF EXPENSES

Name of person receiving services	Relationship to employee	Provider of services*	Deductible or Co-Pay	Dates of service ** From Mo/Day/Yr	To Mo/Day/Yr	**Amount to be reimbursed**
					TOTAL	

* "Provider" means hospital, doctor, dentist, drugstore, medical supply store, etc.
** Use date on which service was provided, not the date you paid for it.

FOR OFFICE USE ONLY	DATE	AUTHORIZATION #	INITIAL

C. DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

Is the facility Tax Exempt?*** Yes ☐ No ☐ Tax ID# or social security # of Day Care provider

SUMMARY OF EXPENSES

Name of person receiving services	Age and grade	Relationship to employee	Provider of services* and address	Dates of service ** From Mo/Day/Yr	To Mo/Day/Yr	**Amount to be reimbursed**
					TOTAL	

* "Provider" means day care center, person who gave care, etc.
** Use date on which service was provided, not the date you paid for it.
***If the facility is Tax Exempt, the I.D. Number is not required.

SIGNATURE OF DAY CARE PROVIDER _____

The above is a true and accurate statement of unreimbursed medical or dependent care expenses provided to me or my eligible dependents on the date(s) indicated.
I have read and understand the information on the back of this form. I understand that I am responsible for misrepresentation regarding requests for reimbursement.

SIGNATURE: _____ **DATE:** _____

FOR OFFICE USE ONLY	DATE	AUTHORIZATION #	INITIAL

FRINGE BENEFITS MANAGEMENT COMPANY
FLEXIBLE SPENDING ACCOUNT
DIRECT DEPOSIT AUTHORIZATION FORM

Before completing this form, read the back and make sure you understand the terms and conditions of the agreement. Fill in the boxes below and sign the form. Mail the completed form to: Fringe Benefits Management Company.
ATTN: Enrollment Processing, P.O. Box 1878, Tallahassee, FL 32302-1878.

Last Name

First Name

MI

Social Security Number

Work Phone

Action

New Change Cancel

Effective Date

Month Day Year

Name of Financial Institution

Account Number

(Include hyphens but omit spaces and special symbols.)

Type of Account

Checking Savings

Routing Transit Number

(All 9 boxes must be filled. The first two numbers must be 01 through 12 or 21 through 32.)

Ownership of Account

Self Joint Other

I certify that I have read and understand the back of this form. By signing this agreement, I authorize Fringe Benefits Management Company (FBMC) to initiate credit entries to the account indicated above for the purpose of reimbursements from my flexible spending account(s). I also authorize FBMC to initiate, if necessary, debit entries and adjustments for any credit entries made in error.

Signature _____ Date _____

If the account is a joint account or in someone else's name, that individual must also agree to the terms stated above by signing below.

Signature _____ Date _____

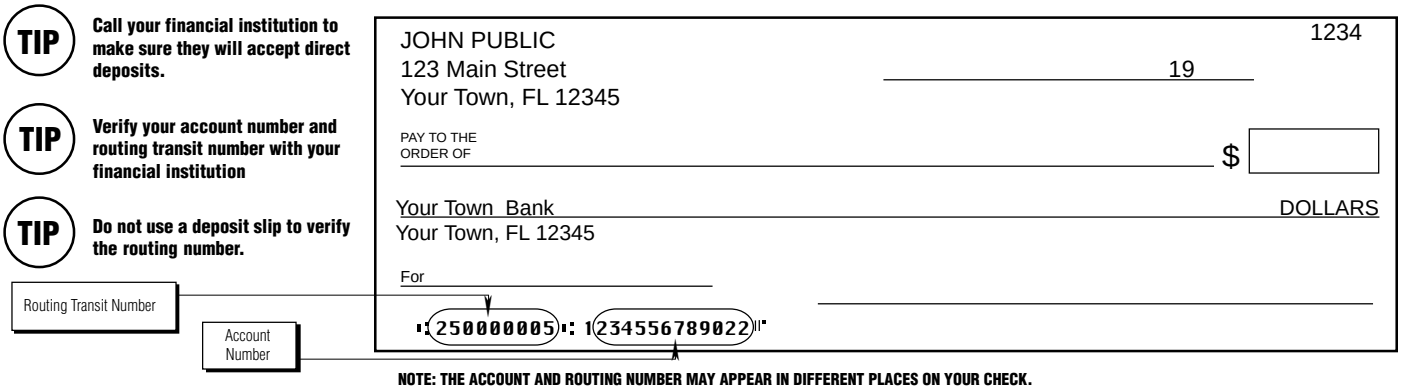
HOW TO COMPLETE THIS FORM

1. Read the back of the form completely.
2. Fill in all boxes above.
3. Sign and date the form.
4. If the account is not in your name alone, have the other account holder sign also.
5. Mail the form to the address listed above.

TIP **Call your financial institution to make sure they will accept direct deposits.**

TIP **Verify your account number and routing transit number with your financial institution**

TIP **Do not use a deposit slip to verify the routing number.**



NOTE: THE ACCOUNT AND ROUTING NUMBER MAY APPEAR IN DIFFERENT PLACES ON YOUR CHECK.

REV 11/97/CONFIRM

TERMS AND CONDITIONS FOR PARTICIPATING IN FLEXIBLE SPENDING ACCOUNT DIRECT DEPOSIT

If you are participating in a flexible spending account (FSA), you have the option of having your authorized reimbursements deposited directly into your account at your financial institution rather than receiving the payment by mail. The following are the terms and conditions for participating in the Direct Deposit program. You do not have to participate in the FSA direct deposit program in order to have an FSA.

1. Your financial institution must be a member of an Automated Clearing House in order for you to participate in the FSA Direct Deposit program.

2. You must complete this authorization form to enroll in the FSA Direct Deposit program. A signed and dated form is required for processing. If you have a joint account, the form must be signed by both parties. Once your form is received by Fringe Benefits Management Company (FBMC), there may be up to a 4 week administrative processing period before the enrollment will become effective. You will receive checks for any reimbursement claims paid during this period. FBMC will mail you a direct deposit receipt and a new claim form each time an electronic transfer is made to your account.

3. You may also verify your direct deposit has been transmitted by calling the Interactive Benefits telephone 1-800-865-FBMC. The standard turnaround time for deposit into your account is 48 hours from the time FBMC transmits the entries. You should verify that the deposit has been made to your account before withdrawing funds.

4. If an electronic transfer is returned to FBMC or for any reason cannot be made to your account, FBMC will investigate the cause and if necessary, will issue and mail a reimbursement check to you. Pending resolution of the electronic transfer problem, you will continue to receive reimbursement checks in the mail. Reinstatement in the FSA direct deposit program will be determined on a case–by– case basis, and you will be notified of any action taken.

5. It is your responsibility to notify FBMC immediately of any changes in your account, such as account closure or change in account number. Complete this form indicating the action is a CHANGE, and specify the new account information. There may be up to a 4 week administrative processing period before the changes become effective. If there is an interruption in the FSA direct deposit service, you will receive checks for any reimbursement claims paid during that time.

6. You may cancel your participation in the FSA direct deposit program at any time by completing this form indicating the action is a CANCEL. The cancellation will take effect as of the date you indicate or as soon as the form is received and processed by FBMC, whichever is later.

7. This agreement may also be canceled by your financial institution or FBMC. FBMC reserves the right to automatically cancel your participation in the FSA direct deposit program upon termination of employment or termination of your flexible spending account(s).

8. If you re–enroll in a flexible spending account, your participation in the FSA direct deposit program along with the terms and conditions of this agreement will remain in effect from one plan year to the next until you cancel.

If you have any questions regarding this form, the FSA direct deposit program or any electronic transfers to your account, call Fringe Benefits Management Company Customer Service at 1–800–342–8017, or the Telecommunications Device for the Deaf (TDD) at 1–800–955–8771, Monday through Friday, 8 a.m. to 10 p.m. EST.

FBMC
Fringe Benefits Management Company
Benefit Continuation Department
(800) 342-8017 • FAX (850) 425-6220

VERY IMPORTANT – SUMMARY OF RIGHTS NOTICE

CONTINUATION OF GROUP HEALTH COVERAGE

As allowed by the Consolidated Omnibus Reconciliation Act of 1985(COBRA), you have the right to continue health coverage if coverage cease/terminates due to the following "Qualifying Event(s)":

a. Termination of employment (including voluntary resignation, involuntary termination, retirement, layoff, or leave of absence) except for termination due to gross misconduct.
b. An Employee whose hours are reduced and who no longer meets the eligibility requirements of the Plan.
c. A surviving spouse and/or eligible dependent(s) of an employee who dies while covered under the Plan.
d. A divorced or legally separated spouse and/or dependent(s) of a covered employee.
e. A dependent child who no longer meets the eligibility requirements of the Plan.
f. A spouse and/or eligible dependent(s) of an employee who is entitled to Medicare benefits.
g. An employee who is disabled at time of termination of employment

Dependent Coverage option
Coverage for eligible dependent(s) may be continued if such coverage would otherwise cease/terminate due to the events described above. If dependent "only" coverage is desired, please indicate this when enrolling. Dependents who are not covered on the day before the qualifying events described above are not eligible for continuation of coverage.

Enrollment Deadline
The option to continue coverage must be exercised within sixty (60) days from the date of the qualifying event or the date of this notice, whichever is later. All qualifying individuals must complete and submit the enclosed Continuation of Benefits application for continuation of health coverage within this sixty (60) day election period.

Cost of Continuation Coverage
The cost of this continuation coverage is paid entirely by the individuals electing such coverage. Rates are established each year and are subject to change annually.

When Continuation Coverage Ends
Continuation coverage will end on the earliest of the following:

Maximum Period – Continued coverage for individuals described in A and B above may continue coverage for a maximum of eighteen (18) months for the last day worked or coverage end date. The maximum period of continuation coverage for those individuals described in C,D,E, and F above is thirty-six (36) months from the date of the qualifying event.

If any person is determined under Social Security Act to have been disabled at the time of termination of employment or reduction in hours worked (or because of his/her spouse's or parent's employer) that person, is entitled to 29 months of COBRA coverage, provided a copy of the notice of disability is sent to FBMC within 60 days after the date of determination and before the end of the first 18 months of COBRA coverage. Federal law allows FBMC to charge an individual 150% of the cost to provide coverage from the 19th through 29th months of coverage. FBMC can terminate the extended coverage the month that begins more than 30 days after the date of a final determination under the Social Security Act that the individual is no longer considered disabled.

FLEXIBLE Spending Accounts – Eligibility continuation through the "end" of your employer Benefit Plan Year.

Other Group Insurance or Entitlement to Medicare Benefits – Continuation coverage for any person ends when that person becomes covered under any other group health plan.
Continuation coverage also ends when any person becomes entitled to Medicare benefits.

Pre-Existing Conditions and COBRA coverage
The Health Insurance Portability and Accountability Act "HIPPA" of 1996 makes it easier for an employee to change jobs and become covered by a new employer's health plan even if the employee (or covered spouse or dependent) has pre-existing medical condition(s). **Note:** A break if coverage more than 63 days may subject you to pre-existing condition(s) exclusions as identified by FBMC or the health coverage provider. When your COBRA coverage ends, you will be provided a "HIPPA Certification" from your health coverage provider identifying your uninterrupted coverage under COBRA.

Payments
FBMC does provide coupon booklets as a courtesy for your use when remitting premium payments.

You must remit the initial premium payment within 45 days of the date you elect coverage. A 30-day grace period is permitted for all subsequent premium payments. Premiums received after the 30-day grace period will be returned and will result in termination of coverage(s).

Failure to Make Required Payments
Continuation coverage will terminate if required premium payments are not made as noted above.
COVERAGE(s) CANCELLED BECAUSE OF FAILURE TO REMIT PAYMENT WHEN DUE, WILL NOT BE REINSTATED FOR ANY REASON.

This information is a summary of your rights, and we hope it has been helpful to you. Please let us know should you have any questions or need assistance.

Sincerely,

Benefit Continuation Department

3101 Sessions Rd., Tallahassee, Florida 32303-5547 • Post Office Box 1878, Tallahassee, Florida 32303-1878

Customer Service 1-800-342-8017 FAX 850-425-6220

FBMC

Fringe Benefits Management Company

Benefit Continuation Department

Continuation of Benefits Application-**COBRA**

Employer #: «ER»

Employee #: «EE»

«Name»
«Address»
«CitySTZip»

Phone Number: _____
Date of Birth: «DOB»
Date of Notice: **28-Oct-02**

Date of Qualifying Event: «QED»

COBRA period of **«Months»** based on «why».

Eligible Benefits to Continue:

BENEFIT	PROVIDER	MONTHLY PREMIUM	CONTINUE? (Y/N)
«bene1»	«provider1»	«rate1»	_____
«bene2»	«provider2»	«rate2»	_____
«bene3»	«provider3»	«rate3»	_____

Dependent Information:

Name: _____ DOB: _____ Relation: _____
_____ _____ _____
_____ _____ _____

Payment Preference:

_____Monthly _____Quarterly _____Semi-Annually _____Annually

Envelope must be postmarked no later than «postmarked».

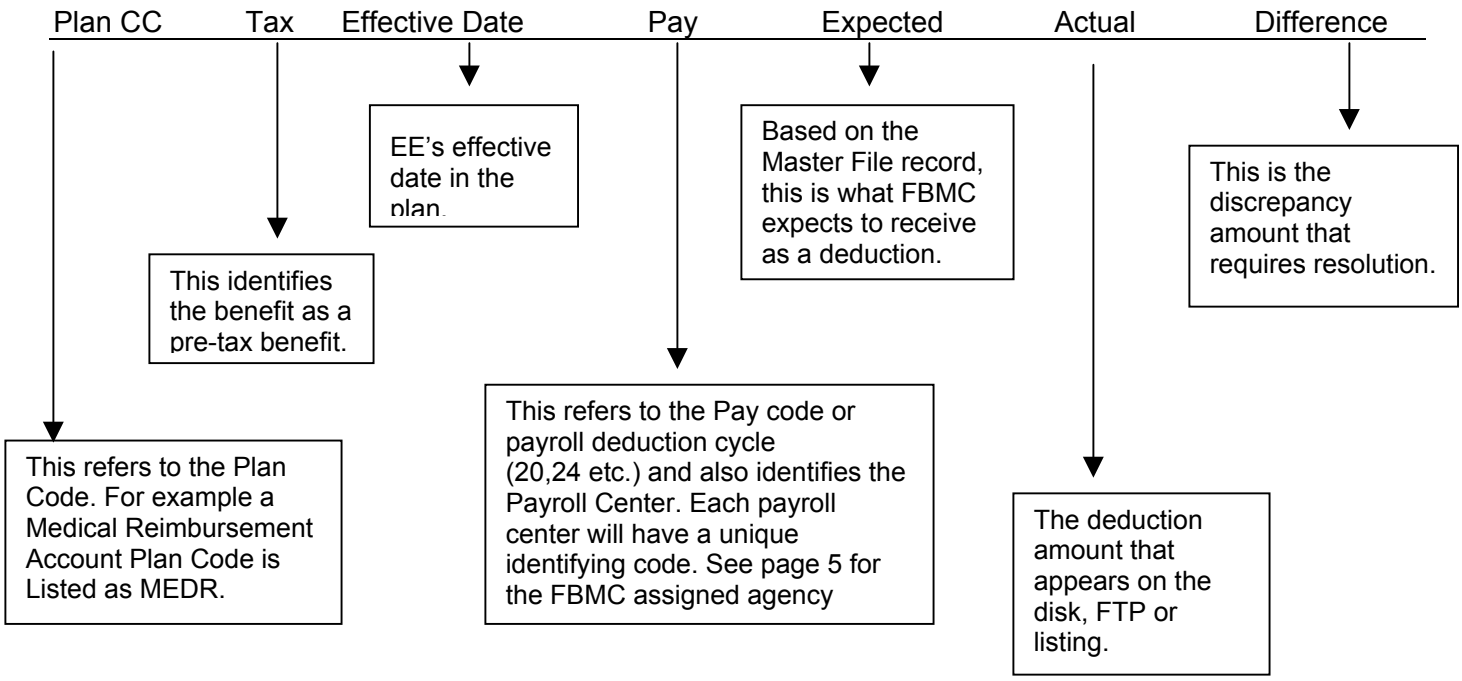
I acknowledge and understand that the benefits and premiums provided to me on this form, may be changed, subject to the provisions of the VISTA Plan and applicable state laws, based upon:

1) The claims experience of the group upon which my existing premiums are based and

2) My former employer's right to modify the benefits provided to the group of which I am a part and to separate and/or combine the claims experience of the COBRA/Retiree group with that of the active employee group for premium determination purposes.

DATE:_____ **SIGNATURE:**_____

Commonwealth of Virginia Payroll Reduction List for 00/00/02 payroll
Job #: 0000 DATE 00/00/02 TIME 00:00:00 Page 1



NOTICE: This Handbook is not intended to be all-inclusive. If conflicts exist between this Handbook and the Internal Revenue Code, Virginia Statutes or the Flexible Benefits Plan Summary Document, the Internal Revenue Code and the Statutes must be followed.